UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

MELINDA FISHER, S.G. by and through her guardian, B.R. by and through his guardian, M.R.M. by and through his guardian, M.S.M. by and through her guardian, and NEAL SIEGEL, on behalf of themselves and all others similarly situated, Plaintiffs, v. KIM REYNOLDS, in her official capacity as Governor of Iowa; JERRY FOXHOVEN, in his official capacity as Director of the Iowa Department of Human Services, Defendants.	Case No. 4:17-cv-00208-RGE-CFB **PLAINTIFF'S BRIEF IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION**

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I. INTRODUCTION

Plaintiffs are Iowans with significant disabilities who are able to live in their own homes and be part of their communities. Plaintiffs are able to reside at home, rather than in institutions segregated from society, because of the supports and services provided under the State of Iowa's Medicaid home and community-based services (HCBS) waiver programs. The Plaintiffs are in jeopardy of losing their community integration because of the actions of the Defendants and their contractors.

In violation of the Medicaid Act, the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act, the Defendant State Officials, through their agents, have denied or made devastating reductions to the services of Iowans who rely on HCBS waivers to maintain their health and lives in the community. These reductions have occurred after April 2016 when the Defendants contracted with three private, for-profit managed care organizations (MCOs) to act on behalf of the State and as agents of the State to operate most of Iowa's Medicaid system, including the HCBS waiver programs, for a monthly capitated rate per member.

The Defendants, moreover, in violation of the Due Process Clause of the Fourteenth Amendment, the Iowa Constitution, the Medicaid Act and regulations, have failed to provide the Plaintiffs and other potential class members with appropriate advance notice that includes individualized reasons why their benefits are being reduced or denied, an explanation of their appeal rights, and have also failed to provide services pending an appeal. Without appropriate due process, the Plaintiffs and other adults similarly situated do not have a sufficient opportunity to challenge improper service reductions and maintain the services necessary to continue to be fully integrated in their communities.

These severe reductions and denials of waiver services have irreparably harmed the Plaintiffs and other adults similarly situated because they are made without regard to the Plaintiffs' actual needs, and because the Plaintiffs do not have sufficient notice to challenge the reductions and denials. In addition, the reductions and denials are causing the plaintiffs' health, abilities and well-being to deteriorate, threatening their lives. It is also causing isolation from the community, and are exposing them to the risk of institutionalization. Plaintiffs are also economically harmed because some are paying out-of-pocket for the services to which they are entitled and for which the Defendants refuse to pay.

With its complaint, the Plaintiffs have filed a motion to certify a class of Iowans similarly situated. The Plaintiffs are filing a Motion for a Preliminary Injunction on behalf of themselves and putative class members.

II. FACTUAL BACKGROUND

The pertinent background for this case is contained in the Plaintiffs' Class Action Complaint and Motion for and Memorandum in Support of the Class Certfication. A brief synopsis of the facts and relevant law is provided here to add context to Plaintiffs' arguments establishing the need for preliminary injunctive relief. Where appropriate, this memorandum refers to facts supported in the previously filed pleadings.

a. The Medicaid Program

The Medicaid Program is a federal program designed to help states provide medical assistance to financially needy individuals, with the assistance of federal funding. *Lankford v. Sherman*, 451 F.3d 496, 504 (8th Cir. 2006). Similarly, the Medicaid Act applies equally whether the state is providing services that are optional or mandatory. *See*, *Lankford*, 451 F.3d at 504 ("Once the state offers an optional service, it must comply with all federal statutory and regulatory

mandates."); *see also, Guggenberger v. Minnesota*, 198 F. Supp. 3d 973, 1004 (D. Minn. 2016). States are required to administer Medicaid "in the best interests of recipients." 42 U.S.C. § 1396a(a)(19).

The state Medicaid agency, the Iowa Department of Human Services, may not delegate the final authority to supervise the program or to develop or issue policies, rules, and regulations on program matters. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10(e); Iowa Code § 249A.4. The DHS Director's non-delegable duties under federal law include exercising appropriate oversight of managed care plans contracted to provide Medicaid services. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 431.10, 438.66. Last year, Iowa began contracting with three private, for-profit managed care organizations (MCOs) to provide Medicaid services in exchanges for a capitated monthly rate for each Medicaid beneficiary enrolled with the MCO. The DHS contract obligated the MCOs to provide due process, and to comply with all federal and state laws. (Attachment A, see sections 1.5.1; 3.2.1, 8.15). It also requires the MCOs to provide services in accordance with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), which held that, under Title II of the ADA, states are required to place persons with mental disabilities in community settings rather than in institutions when the State's treatment professionals determine that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with disabilities. *Id.* at 607.

During the first year of operation, the managed care companies say they lost money and asked the state for additional funds The State first agreed to pay them $33.2 million more from the state treasury, which brought $94.5 million dollars in a federal match. (Attachment B) The State has subsequently agreed to "risk-corridor" agreements which would help the companies

make up for what they say is an alleged $450 million in losses since the MCOs began delivering services in Iowa's Medicaid program. The Iowa Department of Human Services estimated that the state's share of the new agreements' cost would be roughly $10 million, payable after June 2018, and the federal share would be up to $225 million. (Des Moines Register, March 29 2017).

Despite these funding increases for the MCOs, Medicaid beneficiaries, many of whom require services 24 hours a day, have seen significant reductions and terminations in services and new caps imposed on HCBS provided under some of the state's waiver programs. These budget limits and and service caps, have resulted in the affected beneficiaries experiencing damage to their health, increased segregation from their communities and risk of institutionalization.

b. Home and Community-Based Waiver Services

State Medicaid programs may apply for waivers to provide home and community-based services (HCBS) to individuals with disabilities. 42 U.S.C. § 1396n. These waivers allow states to provide service funding and individualized supports through a variety of services to maintain eligible Medicaid members in their own homes and communities who would otherwise be forced into institutional settings, such as an intermediate care facilities or nursing facilities. Iowa has seven HCBS waivers. The three waivers at issue in this case are: 1) the Intellectual Disability (ID) Waiver, 2) the Brain Injury (BI) Waiver, and 3) the Health and Disability (H&D) Waiver. To receive services through any of these waiver programs, applicants must establish that they meet eligibility criteria, including a showing that they require an institutional level of care. As of April 1, 2016, waiver services are provided by MCOs under their contract with the state.

Each of the waivers offers a slightly different array of services and has different criteria, but all must follow the requirements of Medicaid generally and HCBS waivers specifically, including providing supports and services commensurate with the individual's level of need,

within the waiver's scope of services. 42 C.F.R. § 441.301(c)(2). Services are individualized to meet the needs of the member. The number of units or budget amount is based on an initial level of care assessment. This level of care assessment is used by an interdisciplinary team to determine the member's needs and to design an individual service plan intended to meet those needs. The service plan describes the type of waiver services, the frequency of services, the type of provider and the manner in which services will be provided. In Iowa, the services can be provided in a traditional setting where an agency is given a specific budget to provide the services. As an alternative, services can be self-directed by the member through either the consumer-directed attendant care (CDAC) service or consumer choices option (CCO) program. The common feature in both of these variations is that the individual or their representative chooses who provides the services. The individual or representative is responsible for arranging and managing those services consistent with the individual's assessment and individualized services plan.

The individual service plan is submitted to DHS for review and approval. Once approved, the MCOs are responsible for monitoring the implementation of the service plan, including access to waiver and non-waiver services, the quality of service delivery, and the health, safety and welfare of members. (Attachment C at p. 163; Attachment A at Sec. 4.4.7). The MCO/DHS contracts also emphasize that for "members who require individualized, enhanced staffing patterns to support them in a less-restrictive setting, the [MCOs] shall not reduce the enhanced staffing arbitrarily or without a supporting reduction in clinical need as documented by provider records." (Attachment A at Sec. 4.1). The MCOs are not permitted to reduce, modify, or terminate services in the absence of an up-to-date assessment of needs that supports the reduction, modification or termination. Any change to services must receive DHS's prior approval. (Attachment A at Sec.

4.3.11; Attachment C at p.160). The Medicaid case manager completes annual reviews to identify the ongoing need for services.

The State must describe in the 1915(c) waiver application any limits or caps on budgets and individual services. The ID, BI and H&D waivers as approved by CMS do not contain an individual cost limit but may have limits on services. The State must also include an explanation of any exceptions process to ensure the health and safety of waiver participants. Iowa's waiver application for each of the ID, BI and H&D waiver states:

> "If there is a need that goes beyond the budget amount and/or the waiver service limit, the participant has the right to request an exception to policy. . . The MCOs operate an exception to policy process for their members. In the event an MCO denies an exception to policy and determines the member can no longer have his or her needs safely met through the 1915(c) waiver, the MCO is required to forward this information to DHS."

(See eg. Attachment C at pg. 200-201)

If an individual needs more services than are allowed by a particular service limit set forth in the approved application for 1915(c) waivers, there must be a review to determine if the member's needs can be met through the exceptions process. Exceptions may be granted to a member when the member has needs beyond the limits expressed in Iowa Administrative Code. (See Attachment C at Appendix E-2). Iowa statutes, the approved waiver applications, and the Defendants' contracts with the MCOs expressly direct the MCOs to consider exceeding these caps if the individual has the medical need for services that cost more than the cap.

c. Summary of Plaintiffs' Needs and Services and the Proposed Cuts to those Services.

The Defendant State Officials, through their agent MCOs, have made across the board significant and devastating cuts and denials to the services and budgets of the Plaintiffs and others similarly situated who are relying on HCBS waivers to maintain their health and lives in their

homes in the community. The named plaintiffs and other similarly situated have chronic, long-term disabilities of the sort that do not improve or change particularly in a few months time. The emotional, physical, and economic strain resulting from the Defendants' failure to arrange for the full range of HCBS services needed by Plaintiffs and potential class members has become untenable. None of the Plaintiffs' needs for services has decreased, but they are all suffering from or appealing drastic cuts in needed services.

Plaintiff Melinda Fisher: Since January, Melinda Fisher has been struggling to get by with fewer than half of the HCBS hours she needs and is facing further cuts, despite the plan established by her interdisciplinary team saying she needs eight hours of assistance per day. Melinda Fisher has been told to look into nursing facility placement and her family has looked at some nursing facilities, but she enjoys living at home and also enjoys her life in the community. She does not want to live in a nursing facility. FAC ¶¶ 119-20.

Plaintiff SG: Plaintiff SG's budget was reduced by 12.4% in August, 2016, and she had to move to an apartment with more roommates, exacerbating her stress and anxiety, causing an increase in medications and increase in frequency of electroconvulsive therapy (ECT) treatments, causing her to lose skills, increasing her isolation, and decreasing her social and other activities in the community. FAC ¶¶ 132-34.

Plaintiff BR: Since Plaintiff BR's budget was cut in November, 2016, his provider issued a notice discharging him from its care as of February because it cannot afford to provide the services he needs at the reduced amount. FAC ¶ 142. BR's provider has continued to provide BR with services until BR's guardian can locate another provider who is able to provide him with services, but if BR's guardian is not able to locate such a provider, BR most likely will have to move back to an institution. FAC ¶¶ 145, 149, Attachment D.

Plaintiff MRM: Plaintiff MRM's budget was cut in March, 2017 from a monthly budget of $8508.88 to $5,376.33, even though he is supposed to receive the same amount of services. However, once the CCO employee wages were reduced there were still service hours not covered in which he needed CCO services. His 70 year old mother has provided him some services without pay, something she will not be able to do indefinitely. FAC ¶¶ 158, 162, 164.

Plaintiff MSM: Plaintiff MSM's services were forced to change in September 2016 from 24 hour daily to approximately twelve hours as the MCO would not consider continuing her exception to policy, and then her service were cut again in March, 2017 from twelve hours down to fewer than eight. FAC ¶¶ 176-77. MSM, who needs constant supervision , has already laid off two of her service providers, and is considering moving out of her home to an institution due to the service cuts. FAC ¶ 184.

Plaintiff Neal Siegel: Although Plaintiff Neal Siegel cannot be by himself for any significant period of time due to his brain injury, his services were cut by 58% in March, 2017 from about ten hours per day average to about four hours per day . FAC ¶¶ 199, 203. Neal Siegel has been able to maintain his previous level of service while appealing, but if his services are cut, Neal Siegel, a former successful financial planner who was injured in a vehicular hit and run while riding his bicycle, may be forced to return to an institution, like one where he previously experienced abuse and neglect. Neal Siegel's life at home is full of family, friends, and activities, as compared to his frustrating, dreary, and sometimes neglectful experience in an institution. FAC ¶ 203, Aff.

All of the Plaintiffs' requested service levels are less costly than the institutional alternative for each of them. All of the Plaintiffs have previous experience with institutionalization or less integrated settings and do not want to return to living in such settings

or have less integration into their communities. The Plaintiffs and the proposed class do not want to be segregated from their communities. They require the services appropriate to their needs and the due process that protects these services when they are reduced, denied, terminated, or not provided with reasonable promptness.

III. STANDARD OF REVIEW

Injunctive relief is "an equitable remedy shaped to right an ongoing wrong[.]" *Kohl v. Woodhaven Learning Ctr.*, 865 F.2d 930, 934 (8th Cir. 1989). This court recently held that a "preliminary injunction 'protects plaintiff from irreparable injury' as well as safeguards 'the court's power to render a meaningful decision after a trial on the merits.'" *Johnson v. Moody*, --- F. Supp. 3d ---, 2016 WL 8839427(S.D. Iowa Nov. 14, 2016) (citations omitted). There are four factors that this Court must consider in determining whether to grant preliminary relief: "(1) the probability of success on the merits, (2) the threat of irreparable harm to the movant, (3) the balance between the harm and the injury that granting the injunction will inflict on other interested parties, and (4) the public interest." *Lankford*, 451 F.3d at 503 (citing *Dataphase Sys. v. C L Sys., Inc.*, 640 F.2d 109, 114 (8th Cir. 1981)). Plaintiffs meet all these factors.

a. Plaintiffs Have Shown a Likelihood of Success on the Merits.

i. Plaintiffs are Likely to Succeed on the Merits of their Claim that the Defendants are Violating Procedural Due Process

The Due Process Clause states that "no state shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const., amend XIV, §1. Similarly, the Iowa Constitution provides that "no person shall be deprived of life, liberty or property without due process of law." Iowa Const., Article I, Sec. 9. In *Goldberg v. Kelly*, 397 U.S. 254, 266-71 (1970), the Supreme Court held that the Due Process Clause requires states to give public benefits recipients meaningful notice prior to termination and to continue benefits pending a pre-

termination hearing before a fair and impartial hearing officer. The Medicaid Act and its implementing regulations require the state Medicaid agency and the MCOs with which it contracts to provide each recipient with adequate written notice and an opportunity for an impartial hearing before services are denied, reduced, or terminated. *See* 42 U.S.C. §§ 1396a(a)(3) and 1396u-2(b); 42 C.F.R. §§ 431.210 and 438.404.

Courts have granted preliminary injunctions when state defendants fail to provide the due process required by the U. S. Constitution and the Medicaid Act, including when an individual's budget for waiver services is affected. In *K.W. ex rel D.W. v. Armstrong*, 789 F.3d 962 (9th Cir. 2015), the Ninth Circuit Court of Appeals granted a preliminary injunction after it found that waiver recipients had been denied due process under the Medicaid Act and the Due Process Clause when the state reduced individuals' budgets for waiver services based on an assessment tool that purportedly captured their "living situation." *Id.* at 966-67. According to the court, "…as a practical matter, calculating a lower budget decreases a participant's Medicaid services, thereby triggering the notice requirements of the Medicaid regulations" and that "once a lower budget is calculated, a participant has already effectively been deprived of the right to receive the same level of services[.]" *Id.* at 971, 973; *see also Guggenberger* at 1021 (finding state failed to provide meaningful notice about why applications for HCBS services were denied); *L.S. v. Delia*, 2012 WL 12911052, at *14 (E.D. N.C. 2012) (finding due process likely violated when waiver participants' budgets were decreased and entering preliminary injunction). As with the Plaintiffs in this case, the budget reductions in these cases were actions by the defendants that reduced Medicaid coverage of services in amount, scope, or both, that were previously available to affected individuals, despite no changes in their underlying conditions or needs. The interest of Plaintiffs in continuing to receive adequate budgets for waiver services and thereby maintain

their health, safety, and community integration is substantial and must be protected from erroneous deprivation through the Defendants' actions.

Courts have also found due process violations when eligibility for coverage is changed according to undisclosed standards. In *M.A. v. Norwood*, 133 F. Supp. 3d 1093, 1099 (N.D. Ill. 2015), for example, the court concluded that the dramatic reduction of Medicaid services that were approved consistent with published rules and policies, without any change in those rules and policies, is considered *prima facie* evidence of arbitrary decision making that violates due process. In *L.S. v. Delia*, the court found that changing a waiver participant's budget in the midst of a 12-month plan year was an action that triggered due process protections. 2012 WL 12911052, at *11 (granting a preliminary injunction).

Finally, constitutional due process and the Medicaid Act require adequate notice be provided to recipients in writing with individualized information that recipients can use to decide whether the agency has made mistakes in terminating their benefits and, if so, how they can contest those mistakes at a hearing. *Goldberg*, 397 U.S. at 266-268; 42 C.F.R §§ 431.205(d) and 438.404. As the Supreme Court has stated, "Adequate notice is integral to the due process right to a fair hearing, for the 'right to be heard has little reality or worth unless one is informed[.]" *Mullane v. Cent. Hanover Bank & Tr. Co*., 339 U.S. 306, 314 (1950).

The Medicaid Act's implementing regulations detail the components of an adequate written notice. The notice must contain, among other things: a statement of the action the agency intends to take; an explanation of the intended action; and the specific regulations that support, or the change in federal law that requires, the action. 42 C.F.R. § 431.210. The notice must be sent to the beneficiary at least 10 days before the anticipated action. 42 C.F.R. § 431.211; 438.404(c). The beneficiary must be able to request that the benefits continue pending the outcome of the

administrative appeal. 42 C.F.R. §§ 431.231(c) and 438.404(b)(6). A state agency may not use the start of a new authorization period to deny continued benefits as such a framework "contravenes the clear directive of the Medicaid Act and basic due process rights delineated in *Goldberg v. Kelly[.]" Jonathan C. v. Hawkins*, No. Civ A 9:05-CV-43, 2006 WL 3498494 at *13 (E.D. Tex. 2006). These protections ensure that a person is able to continue to receive necessary services without interruption until they receive a decision from a fair hearing in which they were able to present evidence as to why they meet the standards and criteria for qualifying for a service.

Medicaid beneficiaries do not have a meaningful way to challenge reductions in services if services are not continued pending appeal. This is due to extremely short reauthorization periods which may expire prior to conclusion of the appeal process. In *Jonathan C.*, the Defendant and its agents reauthorized services every 60 days. They reduced by 20% the private duty nursing services for a beneficiary during the reauthorization period. The Plaintiff appealed, but the Defendant refused to continue services pending the appeal, based on Texas state law. The beneficiary won after the reauthorization period ended. The defendant again reduced the services for the next reauthorization period. The court found that the plaintiff was subjected to a "cycle of denial" because, the authorization period will have expired or be near expiration by the time a favorable fair hearing decision is issued. *Id.* at *14.

Courts have routinely enforced the notice and hearing requirements of the Medicaid Act. *See, e.g., Granato v. Bane*, 74 F.3d 406 (2d Cir. 1996); *Catanzano v. Dowling*, 60 F.3d 113 (2d Cir. 1995); *Featherston v. Stanton*, 626 F.2d 591 (7th Cir. 1980); *Easley v. Arkansas Dept. of Human Services, Div. of Social Services*, 645 F. Supp. 1535 (E.D. Ark 1986).

Here, none of the Plaintiffs in this case experienced any changes in their care needs, nor have the Iowa Medicaid rules changed. Yet, all of the plaintiffs have had their monthly budgets and services slashed significantly and their requests for exceptions to maintain coverage denied. (Fisher Decl.¶ 21, 29, 36, Schmitt Decl. ¶ 7-8, Johnson Decl. ¶ 11, 15, Doocy Decl. ¶ 13-15, Kuhl Decl. ¶14-16, 18, Wargo Decl. ¶ 16-17). In addition, with the exception of Melinda Fisher, the actions of the Defendants to dramatically alter the Plaintiffs' services occurred in the middle of their 12-month plan of services.[1] These actions, when taken by other Medicaid agencies and agents, have been enjoined as violating due process and the Medicaid Act.

Further, the named Plaintiffs were not provided with appropriate notice and the opportunity for a hearing, including rights to continued services pending their appeals. Plaintiff Melinda Fisher did not receive advance written notice denying her request for 1000 units per month of CDAC for the January 1, 2017 to March 31, 2017 time period. Instead, the MCO approved only 480 units. She was informed orally of the MCO's decision through a team meeting called by her case manager on December 14, 2016. (Fisher Decl. ¶ 22). Melinda Fisher's brother and sister, with her consent, called the MCO to appeal and was provided incorrect information—namely, being told on the phone that the appeal needed to be filed with the case manager.(Fisher-Doyle Decl. ¶ 4-6). Melinda Fisher eventually received a letter from the MCO denying coverage on January 17, 2017; however, the letter was dated January 5, 2017--four days after the January 1 requested start date for the CDAC and 21 days after the December 14, 2016 team meeting informing Melinda Fisher of the reduction in services. Finally, Melinda Fisher's services were indeed reduced as of January 1, 2017, before she received any written notice or had an opportunity to appeal the decision. (Fisher Decl. ¶ 26).

[1] Ms. Fisher asked for additional Medicaid services when she had a change in the non-Medicaid supports available to her. Fisher Decl. ¶_,

Similar to Melinda Fisher, Plaintiff Neal Siegel only received a notice of his CCO budget reduction *after* his budget had already been reduced. (Wargo Decl. ¶ 18). Neal Siegel appealed the reduction and after a state fair hearing, his MCO was ordered to consider an exception to policy. (Attachment E).

MSM has never personally received a written notice from her MCO regarding cuts to her CCO services. In March, her case manager orally informed her that her services would be cut by 568 units, from 1528 to 960. (Kuhl Decl. ¶18). Although MSM's sister, Olivia, called to request a copy of the notice of this reduction, to request an expedited appeal, and to have MSM's benefits continue pending the appeal, she did not receive a written notice until Plaintiffs' counsel requested it in May. The MCO denied her request to continue benefits stating she did not appeal within 10 days of the written notice that she never received. (Kuhl Decl. ¶20).

MRM filed a timely appeal from the initial decision by his MCO on February 13, 2017. After the MCO denied his appeal on March 16, 2017, he timely requested a fair hearing. He also timely requested that his benefits continue pending both the appeal and the fair hearing. but the MCO failed to provide continued benefits in violation of due process requirements. (Doocy Decl. ¶ 15). Due to the lack of services, MRM has paid his employees from his savings account, and his 70-year-old mother has provided services without pay that would have been provided by his workers for 28 hours per month to reduce the overall cost of services, something she cannot continue to do because of her age and health. (Doocy Decl. ¶ 18). The hearing officer ordered his MCO to reconsider an exception to policy. (Attachment F). However, the MCO again denied MRM's request for a CCO budget of $8511.93 on June 1, 2017, citing the same contract language it relied upon in the previous fair hearing that was rejected by the ALJ. The MCO again denied continued benefits pending appeal, claiming that a new authorization period with a

lower budget had begun—thus trapping MRM in the same cycle as the beneficiary in *Jonathan C.* (Doocy Decl. ¶ 19-21; Attachment G). In violation of constitutional due process and the Medicaid Act, the Defendants have imposed such short reauthorization periods that MRM repeatedly is without services. Defendants refuse to continue his services pending an appeal and are forcing him to file an appeal for each new, but short, reauthorization period of 90 days.

BR's Medicaid and due process rights are similarly being violated. Neither BR nor his legal guardian, Jayna Johnson, ever received written notice from the MCO that his budget would be reduced by 45%. The only notice they have received was a discharge notice from BR's provider on December 30, 2016. (Johnson Decl. ¶ 11-12). Despite the sharp decrease in BR's monthly service budget, the MCO denied BR the right to file an appeal, insisting that it was a provider rate issue and the MCO had thus not taken an action related to BR's services. (Johnson Decl. ¶ 15).

Neither SG or her legal guardian ever received any notice from the MCO. (Graper Decl. ¶ 10).

The plaintiffs and others similarly situated have shown that they have a likelihood of success on their constitutional and statutory due process claims. The named plaintiffs and others similarly situated have chronic, long-term disabilities of the sort that do not improve or change in a few months' time. They all had 12-month service plans and corresponding budgets crafted to meet their needs prior to the transition to managed care. The MCOs ratified plaitiffs service needs following the transition to managed care. Sevices that were found to be necessary in one quarter were then suddenly and arbitrarily said to no longer be necessary the next quarter with absolutely no evidence of a change in their conditions.

ii. Plaintiffs are Likely to Succed on the Merits of their Claim that the Defendants' Failure to Use Ascertainable Standards Violates Substantive Due Process.

To comply with due process, a State Medicaid program must use reasonable, ascertainable, non-arbitrary standards and procedures for determining eligibility for and the extent of medical assistance provided. "Unless a person is adequately informed of the reasons for denial of a legal interest, a hearing serves no purpose and resembles more a scene from Kafka than a constitutional process." *Gray Panthers v. Schweiker*, 652 F.2d 146, 168 (D.C. Cir. 1980); *See also, Dilda v. Quern*, 612 F.2d 1055, 1057 (7th Cir. 1980) (holding that in reduction in welfare benefits due process required detailed "breakdown of income and allowable deductions" in notice).

Courts have held the lack of ascertainable standards deprives individuals of due process. In gauging eligibility for a program or benefit, state agencies must use ascertainable standards that are applied in a rational and consistent manner. *Holmes v. New York City Hous. Auth.*, 398 F.2d 262, 265 (2d Cir. 1968); *see also, e.g., Casey v. Quern*, 588 F.2d 230, 232 (7th Cir. 1978). In the Medicaid HCBS waiver context, courts have repeatedly held that standards determining waiver services, any limits on those services, and available exceptions processes be ascertainable to the waiver participant. In *Michael T. v. Bowling*, 2016 WL 4870284 at *11 (S.D.W.Va. 2016) the court found the lack of transparency in state's process for budgeting and granting exceptions was "potentially—if not effectively—standardless. Such a potentially rudderless determination creates a high risk of arbitrary and erroneous benefits determinations and, as such, is impermissible under the Due Process Clause." Similar cases have found processes for determining HCBS waiver budgets to lack the ascertainable standards necessary for waiver participants to understand cuts to services and have the information necessary to appeal those

determinations. *See, e.g., K.W.*, 789 F.3d at 971-974; *Cyrus v. Walker*, 409 F. Supp. 2d 748 (S.D.W.Va. 2005); *L.S* , 2012 WL 12911052, at *12; *Baker v. State, Dep't of Health & Soc. Servs.*, 191 P.3d 1005, 1011 (Alaska, 2008).

Defendants' agents are using vague, subjective, arbitrary and secret criteria and procedures for determining the amount, duration, and scope of Plaintiffs' HCBS services. In the few cases here where written notices of reductions and denials are sent, they are confusing, often stating the decision was based on medical or physician reviews when in actuality they were made by ulitization staff only. The factual information about the member's needs directly contradict the decision made and notices contain inaccurate information about the Iowa Administrative Code. For example, MSM's initial notice states her request for 1528 units of CCO is unable to be approved and the decision was based on Medical Director Review. However, the reasons cited therein indicate she cannot use the daily rate, which she was not requesting, and then falsely states the Iowa Administrative Code caps the monthly allotted units to 960. (Attachment H, Kuhl Decl. ¶ 24; Iowa Admin. Code 441-78.41(g)(2)). In Melinda Fisher's case, the initial notice states she requires physical assistance with most activities of living including transfers but later denies the continued use of 1000 units of CDAC stating it is not medically necessary and there is no documentation of this level of daily care tasks. (Fisher Decl. ¶ 27). The reality is that the MCOs are making arbitrary cuts to the capped amounts, without any consideration of the member's assessed needs and with no evidence to support the decision. The process leaves the plaintiffs and class members guessing at what the standards are, what evidence they need to present, and what they need otherwise to do to meet the standards for approval.

Defendants are also using secret standards when applying the exceptions process for additional services. The named plaintiffs have requested exceptions to caps or policies through

their case managers when the case manager seeks authorization from the MCO either on the next 30, 60 or 90 day authorization period for the individual assessed services. (Doocy Decl. ¶ 12-13, Fisher Decl. ¶ 19-20, Wargo Decl. ¶16). Prior to April 2016 when Medicaid was privatized, exceptions were routinely granted by DHS when requested with supporting information. Since privatization, despite having a process provided for in the approved waivers, Iowa regulations, and the contracts with the MCOs, Plaintiffs have been denied exceptions and either have not received written notice, such as in the case of Melinda Fisher, MSM, MRM, and Neal Siegel, or the notices they have received have provided no information about the criteria for denying an exception. Not only are they not informed as to why they do not meet the standards for an exception, but the Plaintiffs are told by their case managers or MCO employees that the MCOs will not consider or grant exceptions, and they can only request services within the limits set by state regulation and cannot request more services. (Doocy Decl. ¶ 13, Kuhl Decl. 15¶, Fisher Decl. ¶ 36, Wargo Decl. ¶ 17). Due process protects against such discouragement, misinformation, and intimidation to effectively deny, reduce, or terminate Medicaid services or limit access to the hearing process. "A system or procedure that deprives persons of their claims in a random manner…necessarily presents an unjustifiably high risk that meritorious claims will be terminated." *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 434-35 (1982). Defendants' authorization criteria for services, including exceptions, are therefore inconsistent with the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution and the Iowa Constitution, and Plaintiffs are likely to succeed on the merits of this claim.

Each of the named Plaintiffs and thousands of others similarly situated are being subjected to a variety of policies carried out in a variety of ways to deprive the Plaintiffs of their constitutional and statutory rights. Similar cases have resulted in a preliminary injunction issued

by the Court to protect people with disabilities from harm. The Court in this case should do no less.

iii. Plaintiffs are Likely to Succeed on the Merits of their Claim that Defendant is Violating the Requirement of Reasonable Promptness.

The Medicaid Act requires that services be "furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). Lengthy wait times for medically necessary treatment have been held by courts to be "unreasonable." *See, e.g., Allen v. Mansour*, 681 F. Supp. 1232 (E.D. Mich. 1986); *Sobky v. Smoley*, 855 F. Supp. 1123, 1148 (E.D. Cal. 1994), ("[T]he Medicaid Act's reasonable promptness requirement, set forth at § 1396a(a)(8), prohibits states from responding to budgetary constraints in such a way as to cause otherwise eligible recipients to be placed on waiting lists for treatment."). The State must "[f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency's administrative procedures." 42 C.F.R.§ 435.930(a). Moreover, when contracting with private actors to carry out functions of the Medicaid program, Defendants have the ultimate responsibility of ensuring compliance with the law and with Medicaid requirements. *See Catanzano v. Wing*, 103 F.3d 223, 230 (2nd Cir. 1996).

There is no dispute that Defendants approved a certain amount of Medicaid-covered HCBS for Plaintiff BR based on an assessment of his needs. FAC ¶¶ 101, 105-07. However, though the Defendants, through their agents, found specific amounts of HCBS to be necessary for BR, they have failed to deliver adequate services for weeks, if not months, after the services were approved. FAC ¶¶ 142-45. BR has had a discharge notice from his current provider since November 2016 with a discharge date of February. FAC ¶ 142. At the time of this filing in July 2017, seven months after the discharge notice, no alternative placement has been found for BR despite efforts by his case manager. (Johnson Decl. ¶ 17).

HCBS are critical, medically necessary services that allow indivdiuals with severe disabilities to live safely and stably in a home setting. Failing to provide such services when necessary, as in this case, violates 42 U.S.C. § 1396a(a)(8). *See Rosie D. v. Romney*, 410 F. Supp.2d 18 (D. Mass. 2006) (finding failure to provide necessary behavioral health services to children with disabilities violated the reasonable promptness provisions). Moreover, merely authorizing services but failing to provide adequate compensation to providers, such that beneficiaries are unable to find providers willing to provide them with the services approved by Medicaid runs afoul of the provision as well:

> A state may not circumvent a statutory duty . . . by under-funding a mandatory Medicaid service to the degree that no health care practitioners can afford to provide the service. Setting reimbursement levels so low that private dentists cannot afford to treat Medicaid enrollees effectively frustrates the reasonable promptness provision by foreclosing the opportunity for enrollees to receive medical assistance at all, much less in a timely manner. To that end, . . . §1396a(a)(8) may be reasonably understood to constrain actions and protocols by a state and its Medicaid administrative and rate-setting agencies that otherwise subvert the statute's intent.

Health Care for All v. Romney, No. Civ.A 00-10833RWZ, 2005 WL 1660677, *10 (D. Mass. July 14, 2005). Similarly, here, Defendants may not avoid their obligations to provide services with reasonable promptness by merely authorizing services that are not actually provided for months, if ever. Accordingly, Plaintiffs have a strong likelihood of success on this claim.

iv. Plaintiffs are Likely to Succeed on the Merits of their Claim that Defendant is Violating the ADA and Section 504 of the Rehabilitation Act.

1. **The ADA and Section 504 Prohibit Discrimination Against Individuals with Disabilities.**

Congress enacted the Americans with Disabilities Act (hereinafter "ADA") to prohibit discrimination by all public entities against people with disabilities. 42 U.S.C. §§ 12131-12165. The goals of the ADA "are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for [individuals with disabilities]." 42 U.S.C. §

12101(a)(7). The Supreme Court has held that unjustified isolation is properly regarded as discrimination based on disability under the ADA. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999).

Title II of the ADA, which governs public programs such as the Iowa State Medicaid program, provides:

> [N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132. Section 504 of the Rehabilitation Act applies the same standards to entities that receive federal financial assistance. 29 U.S.C. § 794(a); *Barnes v. Gorman*, 536 U.S. 181, 184-85 (2002); *Bragdon v. Abbott*, 524 U.S. 624, 631-32 (1998). Under the ADA, a "qualified individual with a disability" is a person who "with or without reasonable modifications to rules, policies or practices" meets the "essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity." 42 U.S.C. § 12131(2). Section 504's definition is substantially similar. *See* 29 U.S.C. § 705(20).[2] In the present case, all Plaintiffs are eligible for Medicaid, a program that receives federal funds, and are qualified persons with disabilities within the meaning of the ADA and Section 504. All Plaintiffs chose to participate in a home and community-based waiver program rather than living in an institutional placement and had approved service plans meeting their needs in the home. (FAC ¶¶ 110-111, 130, 137-138, 153, 168, 172, 192-195). Some used HCBS services to intentionally get out of institutions. (FAC¶¶ 140-141, 190-195). Under the currently proposed or actual reductions, cuts

[2] ADA regulations define disabilities, with respect to an individual, to include "a physical or mental impairment that substantially limits one or more of the major life activities of such individual … such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working." 28 C.F.R. § 35.108. The Section 504 requirements are essentially the same. 28 C.F.R. § 41.31.

or denials of their proposed budgets, the "choice" now presented to Plaintiffs is 1) placement out of the community home, in an intermediate care facility (ICF/ID) or nursing home, with a custodial level of care or 2) services under the waiver that are far less than what they have been determined to need and have previously received and which do not meet their health and welfare needs. In Melinda Fisher's case, if she remains in her own home with only 1.44 hours of service, she states she will have to choose between eating, getting her catheter drained, or having her medication provided, but will not be able to have any of the other essential tasks performed. (Fisher Decl. ¶ 32).

2. The "Integration Mandate" of the ADA and Section 504 Prohibit Unjustified and Unncessary Institutionalization.

In enacting the ADA, Congress found that segregation of persons with disabilities, especially in institutions, is a form of discrimination. 42 U.S.C. § 12101(a)(2), (3), and (5). The ADA's integration mandate requires public entities to "administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." *Olmstead*, 527 U.S. at 592; 28 C.F.R. § 35.130(d). The *Olmstead* Court explained that the holding "reflects two evident judgments." *Olmstead*, 527 U.S. at 600. "First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id*. "Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id*. at 601.

The ADA's integration mandate requires states to ensure that services are administered to people with disabilities in the most integrated setting appropriate to their needs, and provides a defense to states only where they can show that it would be a fundamental alteration of their

service systems to do so. *Olmstead,* 527 U.S. at 591-92, 603; *Davis v. Shah* , 821 F.3d 231, 262-64 (2d Cir. 2016); *Radaszewski ex rel. Radaszewski v. Maram,* 383 F.3d 599, 607 (7th Cir. 2004); *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1181-83 (10th Cir. 2003); *Hahn ex rel. Barta v. Linn County IA*, 130 F.Supp.2d 1036, 1052 (N.D. Iowa 2001). Similarly, the Rehabilitation Act regulations require that federally-funded programs be administered "in the most integrated setting appropriate to the needs of qualified handicapped persons." 28 C.F.R. § 41.51(d). The integration mandates of the ADA and Section 504 are virtually identical and are applied in the same manner. *See Davis,* 821 F.3d, at 259-62; *Radaszewski ex rel. Radaszewski*, 383 F.3d at 607.

In analyzing the integration mandate, the *Olmstead* Court held that "unjustified isolation" is "properly regarded as discrimination based on disability." *Olmstead,* 527 U.S. at 597. The Court interpreted the "integration mandate" to require persons with disabilities to be served in the community rather than in institutions when community placement is appropriate, the community setting is not opposed by the affected individual, and the placement can be reasonably accommodated. *Id.* at 607.

Under the ADA and the Rehabilitation Act, the key question is whether services are provided in the "most integrated setting," which according to *Olmstead* is the setting which "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." *Olmstea*d, 527 U.S. at 592, citing 28 C.F.R. Pt. 35, App. A. The integration mandate extends to all settings and covers claims by individuals seeking services to maintain themselves in the most integrated setting possible. *Steimel v. Werrnert,* 823 F.3d 902, 910-914 (7th Cir.

2016). The lives of individiuals with disabilities have improved significantly with the enforcement of the Olmstead decision. [3]

Plaintiffs and others similarly situated meet the *Olmstead* elements. All named plaintiffs are at immediate risk of having to enter settings which are not integrated, contrary to their right to remain in their own homes in the community. (FAC ¶¶126, 136,149, 167, 185, Fisher Decl. ¶ 32-33, Wargo Decl. ¶ 24). All plaintiffs are qualified individuals with disabilities under the ADA. Their doctors and the Defendants' own assessments have determined that in-home services are appropriate for them; none of the Plaintiffs opposes community placement. (Fisher Decl. ¶40, Johnson Decl. ¶14, 20; Attachment D; Attachment I). Requiring Defendants to ensure that Plaintiffs receive the very services they contracted with the MCOs to provide cannot be construed as an unreasonable request.

Several of the plaintiffs have or will have cuts to their services that previously allowed them to participate in the greater community. For example, both MSM and SG cannot go out into the community without substantial support. SG is now limited in her ability to go to Sunday church and regular dance events and frequently has to either arrive late or leave early to accommodate staffing. (Graper Decl. ¶ 16). MSM needs someone with her to ensure she is safe due to her naivety and also to assist her in keeping appropriate boundaries with others she encounters. (Kuhl Decl. ¶13). Further, MSM has been more integrated in this community

[3] The Effects of Community vs. Institutional Living on the Daily Living Skills of Persons with Developmental Disabilities? Research reviewed and summarized by Charlie Lakin, Sheryl Larson, and Shannon Kim University of Minnesota, Institute on Community Integration (UCEDD) *available at* http://www.nasddds.org/uploads/documents/EBP_Brief_1_Mar_14_2011.pdf; Olmstead Enforcement Update: Using the ADA to Promote Community Integration, Statement of Thomas Perez, Asst. Attorney General, Civil Rights Division, U.S. Dept. of Justice before Senate Committee on Health, Education and Welfare, June 21, 2012 *available at* http://www.nasddds.org/uploads/documents/DOJ-Perez-SenateHELP6-21-2012.pdf; Voices from the Olmstead Decision, U.S. Department of Justice, *available at* https://www.ada.gov/video/voices-olmstead.html; Faces of Olmstead, U.S. Department of Justice, Olmstead: Community Integration for Everyone, *available at* https://www.ada.gov/olmstead/faces_of_olmstead.htm.

placement than ever before; unlike in previous settings, at her current placement, MSM enjoys frequently going to social events, Special Olympics, church, leisure programs, family vacations, birthday parties with friends, and other activities. (*Id.* at ¶28). Defendants have a system for providing in-home care services. They must now ensure that those services are in fact provided to Plaintiffs in a non-discriminatory manner.

b. Plaintiffs will be irreparably harmed without the issuance of a preliminary injunction

"To succeed in demonstrating a threat of irreparable harm, 'a party must show that the harm is certain and great and of such imminence that there is a clear and present need for equitable relief.'" *Roudachevski v. All American Care Centers, Inc.*, 648 F. 3d 701, 706 (8th Cir. 2011)(*quoting Iowa Utils. Bd. v. Fed. Commc'ns Comm'n*, 109 F.3d 418, 425 (8th Cir. 1996)).

It is well settled that a denial of Medicaid benefits constitutes irreparable harm. *See, e.g., Kai v. Ross*, 336 F.3d 650, 656 (8th Cir. 2003) ("[D]anger to plaintiffs' health, and perhaps even their lives, gives them a strong argument of irreparable injury"); *Henderson v. Bodine Aluminum, Inc*., 70 F.3d 958, 961 (8th Cir. 1995) ("It is hard to imagine a greater harm than losing a chance for potentially life-saving medical treatment."). In *K.W.***,** the court held that a lower calculated budget to Medicaid participants deprives them of their property interest, and a new lower calculated budget equals a loss in the right to have a service plan equal in value to the previous service plan. *K.W.*, 789 F.3d at 973. In *L.S.*, the court found the plaintiffs faced irreparable harm from the failure to provide due process and the loss of services resulting from a decreased budget, since the plaintiffs had shown that they were experiencing "deteriorating and regressive behavior from lack of services, serious financial strain on plaintiffs' families, and for some, the threat of being institutionalized, as a result of reduced budgets[.]" 2012 WL 12911052 at *14 (E.D. North Carolina 2012). The *L.S.* court went on to hold that "the serious physical and mental

entry or forced entry into an institutional setting for many of the named plaintiffs and members in the class if injunctive relief is not provided constitutes irreparable harm." *Id.* at *15. Not only will Medicaid recipients' health be harmed by a loss of Medicaid services, but the changes in HCBS services may improperly isolate individuals from their communities and put them at risk of institutionalization. Institutionalization would cause an inevitable deterioration in the mental and physical health of the Iowa recipients. In *Crabtree v. Goetz*, 2008 WL 5330506, at *30 (M.D. Tenn. Dec. 19, 2008), the Court said that home care service cuts will cause irreparable injury because "institutionalization will cause Plaintiffs to suffer injury to their mental and physical health, including a shortened life, and even death for some Plaintiffs."

Many of the plaintiffs in this case have personally experienced harm from institutionalization and from not living in the most integrated setting appropriate to their needs. Neal Siegel suffered abuse in his previous placements. (Wargo Decl. ¶ 8). Not only has he been much safer in his current setting, he has been significantly more integrated with his community and family. (Wargo Decl. ¶ 12-13). In previous placements, MRM had major issues with housemates and was picked on by staff which increased his behaviors and depression, and resulted in increased medication and mental health therapy. (FAC ¶¶ 151). Melinda Fisher previously was kept bed bound when recovering from a broken leg in a nursing facility due to lack of facility staff. The proposed cuts down to 1.44 hours a day will put her health and life in serious jeopardy and force her to seek nursing facility care. Melinda needs CDAC services to assist with nearly all daily living tasks and personal cares such as transferring from bed to chair or to her wheelchair, toileting, dressing, prepping meals and helping her eat, medication management, shopping, and transportation to medical appointments. Without these CDAC services, she will be bed bound, without water and food, will have no one to change her

incontinence briefs and empty her catheter bag, no one to give her medications and no ability to get to medical appointments. Fisher Decl. ¶ 32, 34). MSM and BR have a similar history of instability when living in foster homes and institutionalization for mental health treatment. (FAC ¶¶ 139, 140, 169). Both have been charged with assault as result of behaviors related to their disability in their previous congregate settings, and they only recently have experienced success in community living due to dedicated and stable care that keeps them safe from themselves and others. FAC ¶¶140, 170). SG was previously sexually exploited at a residential care facility due to lack of staff supervision. (Graper Decl. ¶ 5, FAC ¶ 130).

The plaintiffs are also suffering economic, mental, and physical harm from increased isolation or risk of reduction of access to the community. Melinda Fisher is paying out of pocket for transportation to medical appointments from her social secutity benefits and cannot afford to pay for transport to any other activity outside the home. (Fisher Decl. ¶ 38). Several plaintiffs have family, friends or legal representatives forced to provide uncompensated services due to reductions and cuts in services in violation of 42 C.F.R. § 441.301(c)(2)(v). (Fisher Decl. ¶ 37, FAC ¶¶ 162, Doocy Decl. ¶ 15, FAC ¶184, Wargo Decl. ¶ 20). Others have been forced to live with more roommates than recommended in their service plans and cannot access community activities due to lack of 1:1 staff. (FAC ¶¶132, 147)) MSM has had to terminate two employees and cut the units covered by others which reduces her ability to leave the home and participate in activities not involving her family. (FAC ¶184; Kuhl Decl. ¶ 27). Neal Siegel is facing out-of-state institutional placement without appropriate HCBS services' which is away from all family and friend supports. (FAC ¶¶126, 136,149, 167, 185, Wargo Decl. ¶ 24-25).

A preliminary injunction to preserve the the pre-cut or pre-denial budgets of the Plaintiffs and the proposed class is necessary to maintain the stability of their current placements and

services so as to prevent irreparable harm from the loss of budget and services and the associated community integration. The harm to Plaintiffs and the putative class is, without doubt, irreparable and includes deterioration of the mental and physical health of these already disabled adults and increased isolation and segregation from the community in violation of their civil and constitutional rights.

c. The Plaintiffs' need for adequate waiver budgets and services to maintain community integration outweighs the potential harm to the Defendants

Courts "must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief." *Amoco Production Co. v. Vill. Of Gambell, AK*, 480 U.S. 531, 542 (1987) . Furthermore, in *Lankford*, the district court held that the Medicaid plaintiffs who were denied the durable medical equipment they need to stay healthy and live in the community had incurred "serious harm" and that the comparative harm to the Defendant was "small." 2007 WL 689749 at *3 (W.D.Mo. March 2, 2007). "Any potential economic impact Defendant may incur from the injunction also does not outweigh the harm Plaintiffs currently suffer." *Id.* (*citing Kansas Hosp. Ass'n v. Whiteman*, 835 F. Supp. 1548, 1553 (D. Kan. 1993) ("Changing Medicaid coverage 'significantly alters the status quo to the detriment of the individual plaintiffs, while its positive budgetary impact on state coffers is negligible in a relative sense.'")). In *Nemnich v. Stangler*, 1992 WL 178963 at *3 (W.D.Mo. 1992), the court recognized that the state "will suffer fiscal problems if enforcement of the amended regulation is enjoined. However, the harm to the plaintiff's life and health clearly outweighs any fiscal harm[.]" And so it is here. Vulnerable adults must not be penalized by the state because private for-profit MCOs who voluntarily assumed the responsibility to care for these individuals at a set contracted rate are cutting services while asking the state for additional payment.

While the Defendants have an interest in fiscal responsibility and in equitably allocating the state's resources, this interest does not preclude injunctive relief in this case. Indeed it demands it. Each of the individuals served in these waiver programs are eligible for and entitled to receive care in either a nursing facility or an intermediate care facility for individuals with intellectual or developmental disabilities (ICF/IDDs). In nearly all cases, the cost of keeping these recipients in their homes or communities is far less than the cost of keeping them in institutions. Most of the named plaintiffs' services, even with the previously approved exceptions budgets, cost less than the monthly total cost of ICF/ID and nursing facility placements. (Doocy Decl. ¶ 26, Fisher Decl. ¶ 33, Kuhl Decl. ¶ 30, Johnson Decl. ¶ 16, Wargo Decl. ¶ 26). The collective cost of providing institutional care for each waiver recipient would significantly exceed the cost of providing waiver services. Requiring the Defendants to comply with the requirements of Medicaid should not be considered a burden. *Illinois Hosp. Ass'n v. Illinois Dep't of Pub. Aid*, 576 F. Supp. 360, 371 (N.D. Ill. 1983) ("Once a state has voluntarily elected to participate in the Medicaid program, …[it cannot] characterize its duty to comply with the requirements of [the program] as constituting a hardship to its citizens."). Ensuring plaintiffs are served in the most integrated setting to meet their needs is the most fiscally responsible approach that Defendants can take and thus the balance of the hardship weighs decidedly in favor of Plaintiffs and Plaintiff class.

d. The Public Interest will be served by a preliminary injunction

When issuing injunctive relief against a government body, the Eighth Circuit has found that enforcement of the federal law is necessarily in the public interest. *Glenwood Bridge, Inc. v. City of Minneapolis*, 940 F.2d 367, 372 (8th Cir. 1991); *see also Lankford*, 2007 WL 689749 at *4; *Heather K. v. City of Mallard*, 887 F. Supp. 1249, 1266 (N.D. Iowa 1995). It is always in the

public interest to prevent a violation of the Constitution. *Planned Parenthood Minnesota, N. Dakota, S. Dakota v. Daugaard*, 799 F. Supp. 2d 1048, 1077 (D.S.D. 2011), *aff'd*, 686 F.3d 889, 893 (8th Cir. 2012) (en banc). Here, the public interest favors granting a preliminary injunction, since an injunction will protect the constitutional rights of Plaintiffs and others, and enforce their rights under federal law. More generally, the public has an interest in ensuring that the Defendants meet their fiscal responsibility. There is substantial public interest in ensuring that persons with disabilities have access to appropriate services and supports.

V. CONCLUSION

Plaintiffs who have received or who are facing cuts to their waiver services endure irreparable harm to their own health and safety. In balancing the equities between Plaintiffs and the state, Plaintiffs risk harm, injury, and segregation from the community as a result of their loss of services. For the state, the amount at issue is relatively small in relation to what it could and likely will cost the Plaintiffs. Given the other cases which have challenged similar schemes, and the clear violations of the constitutional and statutory law, Plaintiffs have shown they are likely to prevail on the merits. It is in the public interest to maintain the Plaintiffs in their own homes and communities and is less expensive to do so. Plaintiffs have met the requirements for a preliminary injunction while the case proceeds. The court should order that the Plaintiffs and the proposed class receive the highest services or budgets that were in place after April 1, 2016, the date on which Iowa privatized its managed care system.

For the foregoing reasons, plaintiffs respectfully request that their motion for preliminary injunction be granted and a hearing set to address preliminary injunctive relief as soon as the Court's schedule permits.

Dated this 18th day of July, 2017.

Respectfully submitted,

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